TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11534

CERTIFICATE OF DEATH

11539

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 7 da.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DENTON
d. STREET ADDRESS: 601 Market St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ANNIE — Middle: Clifton — Last: Anders

4. DATE OF DEATH: Month: 8 — Day: 24 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: JANUARY 5, 1888

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WIFE

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): GRASONVILLE Q.A.Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Henry Clifton

14. MOTHER'S MAIDEN NAME: Sally Ann Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 218-07-0763-D

17. INFORMANT: Daughter — Mrs. Marie A. Cooper — Address: 3122 Welsh Road Philadelphia, Pa. 19136

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma of — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): breast to right axilla, left — DUE TO
(c): lung & pleura

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive on _____, 19___, and that death occurred at 1:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: E. C. H. Schmidt — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 25 Aug 67

22c. PHYSICIAN'S NAME (Type): E. C. H. Schmidt

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: August 28, 1967

23c. NAME OF CEMETERY OR CREMATORY: Chesterfield Cemetery

23d. LOCATION (City or Town) (County) (State): CENTREVILLE Q.A.Co. Md.

24. FUNERAL DIRECTOR: John H. Barton Jr. — ADDRESS: Barton Bros. Centreville, Md.

25a. REC'D BY REGISTRAR DATE: AUG 29 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11535

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11540

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: Mins.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Preston
d. STREET ADDRESS: Noble Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle HARRY Last BLADES — William Harry Blades

4. DATE OF DEATH: Month 8 Day 29 Year 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 20, 1911
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mechanic
10b. KIND OF BUSINESS OR INDUSTRY: auto
11. BIRTHPLACE (State or foreign country): Bethlehem, Maryland
12. CITIZEN OF WHAT COUNTRY? usa

13. FATHER'S NAME: Charles Blades
14. MOTHER'S MAIDEN NAME: Minnie Williamson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 216-09-7511
17. INFORMANT Address: Pauline M. Blades, Preston, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO (b): Essential Hypertension
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Louis S Welty M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
for DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 8-29-67

EXAMINER'S NAME (Type): Louis S, Welty
Address (Street, city, town, or county)

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Sept. 1, 1967
23c. NAME OF CEMETERY OR CREMATORY: Junior Order Cemetery
23d. LOCATION (City or Town) (County) (State): Preston, Maryland

24. FUNERAL DIRECTOR ADDRESS: J. J. Framptom and Son, Fredericksburg, Maryland
25a. RECEIVED BY REGISTRAR DATE: AUG 31 1967
25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11536

CERTIFICATE OF DEATH

11542

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove duplicate papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b: 2 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Caroline
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Federalsburg 21652
   d. STREET ADDRESS: Vesper Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ROY Middle ORVILLE Last BOWMAN (Bowman / Boy)

4. **DATE OF DEATH**: Month 8 Day 13 Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 1, 1901

9. AGE (In years last birthday): 66 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer and Trucker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Laurel Fork, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: J. Edward Bowman

14. MOTHER'S MAIDEN NAME: Nancy Jane Marshall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-36-5093

17. INFORMANT — Address: Mrs. Esther H. Bowman, Federalsburg, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the prostate
DUE TO (b): wide spread metastases
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1 Jan, 1955, to 13 Aug, 1967, that (I) (we) last saw the deceased alive on 13 Aug 1967, and that death occurred at 1:30 P.M. from cause and on the date stated above.

22a. SIGNATURE: Thurston Harrison — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 14 Aug 67

22c. PHYSICIAN'S NAME (Type): THURSTON HARRISON

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 16, 1967

23c. NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery

23d. LOCATION (City or Town) (County) (State): Federalsburg, Maryland

24. FUNERAL DIRECTOR: Frampton Funeral Home — ADDRESS: Federalsburg Md

25a. REC'D BY REGISTRAR DATE: AUG 18 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11537

CERTIFICATE OF DEATH

11543

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 18 da
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Preston, Md. RFD. (Harmony)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Edith — Middle: Louise — Last: Cohee

4. DATE OF DEATH: Month: 8 — Day: 11 — Year: 1967

5. SEX: fem.

6. COLOR OR RACE: white

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: May 8, 1915

9. AGE (In years last birthday): 52 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (County & State, or foreign country): Caroline Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank B. Miller

14. MOTHER'S MAIDEN NAME: Roxie Bowdle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 219-05-8839

17. INFORMANT: Benjamin L. Cohee — Address: Preston, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): RESPIRATORY FAILURE
DUE TO
(b): CEREBROVAICULAR ACCIDENT POST-OPERATIVE.
DUE TO
(c):

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: (a) — (b) 14 DAYS — (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): TOTAL ABD HYSTERECTOMY PRECEEDING CVA

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/25/67, 19 to 8/11, 19 67, that (I) (we) last saw the deceased alive on 8/11 19 67, and that death occurred at 1:30 P M, from causes and on the date stated above.

22a. SIGNATURE: Justin T Callahan — M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): JUSTIN T. CALLAHAN

22d. ADDRESS: BOX 1108 EASTON MD

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: Aug. 14, 1967

23c. NAME OF CEMETERY OR CREMATORY: Jr. Order Cem.

23d. LOCATION (City or Town) (County) – (State): Preston, Md.

24. FUNERAL DIRECTOR: Harvey Wiseman — ADDRESS: Federalsburg, Md.

25a. REC'D BY REGISTRAR DATE: AUG 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Items 20&21 Film 392
9-20-67 ams

11538

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11544

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME(S)
6M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn): Trappe (Rural) 20-1
d. STREET ADDRESS: RFD #1 Box 118
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First John Wesley Middle Coleman, Sr. Last
4. DATE OF DEATH: Month August Day 30 Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: July 24, 1926
9. AGE (In years last birthday): 41 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming & Waterman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Howard L. Coleman
14. MOTHER'S MAIDEN NAME: Clara Skipper
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dotes of service)
16. SOCIAL SECURITY NO.: 213-22-8677
17. INFORMANT: Mrs. John W. Coleman, Sr. Address: Trappe, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured cervical spine
DUE TO (b): Auto accident
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
8234
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

2Da. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Driver of farm truck which ran off road
2Dc. TIME OF INJURY Month, Day, Year: Hour a.m. / p.m. 4 p.m. 8-30 1967
20d. INJURY OCCURRED While at work [X] Not While at work [ ]
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Public road
2Df. (City or town) nr Trappe (County) Tal (State) Md

21. I certify thot I took chorge of the remoins described above, held on Autopsy [ ], Inspection [ ], Inquiry [ ], ond in my opinion deoth resulted from: Noturol couses [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined monner [ ]

ACTUAL SIGNATURE: Louis O Welty M.D.
EXAMINER'S NAME (Type): WELTY
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county):
22. DATE SIGNED: 9-1-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/2/1967
23c. NAME OF CEMETERY OR CREMATORY: Upper Bambury
23d. LOCATION (City or Town): Trappe, Md. (County) (State)

24. FUNERAL DIRECTOR: NEWNAM FUNERAL HOME, Easton, Md. ADDRESS
25a. REC'D BY REGISTRAR DATE: SEP 6 1967
25b. REGISTRAR'S SIGNATURE: Juanita Jorge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11539

11545

CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corparate limits, write RURAL and give neorest town): EASTON
   c. LENGTH OF STAY IN 1b: 2 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address): Memoria l Hospital

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before odmission)
   a. STATE: MARYLAND
   b. COUNTY: Queen Anne's
   c. CITY OR TOWN (If outside corparate limits, write RURAL ond give nearest tawn): STEVENSVILLE
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Shirley — Middle: Vinson — Last: Compton

4. **DATE OF DEATH**: Month: Aug — Doy: 23 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Nov 14 1893

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of wark done during most of working life, even if retired): HOUSEKEEPER

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & Stote, or foreign country): WAYNE Co. W. VA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: FRANK VINSON

14. MOTHER'S MAIDEN NAME: ZEA REYNOLDS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO

16. SOCIAL SECURITY NO. (If yes give wor or dotes of service):

17. **INFORMANT** Address: MRS MARTIN ROBINSON STEVENSVILLE Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Acute M.I. — INTERVAL BETWEEN ONSET AND DEATH: 2 days
   DUE TO: Arteriosclerotic heart disease
   H201
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b):
   DUE TO:
   (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive on Aug 23 1967, and that death occurred at 3:05 M, fram causes and on the date stated above.

22a. SIGNATURE: J. R. Caldwell — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/23/67

22c. PHYSICIAN'S NAME (Type): J. R. Caldwell, M.D.

22d. ADDRESS: Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: Aug 26, 1967

23c. NAME OF CEMETERY OR CREMATORY: PINE HILL

23d. LOCATION (City or Town) (County) (State): PINEHILL Wicomico ~~Kentucky~~

24. FUNERAL DIRECTOR: Ellis Clark — ADDRESS: Easton Md

25a. REC'D BY REGISTRAR — DATE: AUG 28 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

11540

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11546

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON MD
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION, (If not in hospitol, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Hurlock
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELMER — Middle — Lost CONAWAY

4. DATE OF DEATH: 4:20 pm — Month 8 — Day 3 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: COL

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-14-11

9. AGE (In yeors last birthday): 56 yrs.
IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Day Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Acme Market

11. BIRTHPLACE (State or foreign country): Preston, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert H. Conaway

14. MOTHER'S MAIDEN NAME: Lettie Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dotes of service)

16. SOCIAL SECURITY ND.: 219-01-4733

17. INFORMANT — Address: James A. Cephas, Hurlock, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Congestive heart failure
DUE TO
Conditions, if any, which gove rise to immediote couse (o), stoting the underlying couse lost.
(b)
DUE TO
(c)
H341
002.2
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Chr.alcoholic,quiescent pulm. th.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes xx, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Louis J Welty M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
for DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Welty
Address (Street, city, town, or county)

22. DATE SIGNED: 8-4-67

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 10, 1967

23c. NAME OF CEMETERY OR CREMATORY: Thompsontown Cemetery

23d. LOCATION (City or Town) (County) (State): Near East New Market, Md.

24. FUNERAL DIRECTOR — ADDRESS: Frampton Funeral Home Federalsburg Md

25o. REC'D BY REGISTRAR — DATE: AUG 18 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11541 Item 3 Film G392 8/25/67 kk

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11547

1. **PLACE OF DEATH**
   a. COUNTY: TALBOT — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
   c. LENGTH OF STAY IN 1b: DOA 2:50A
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: S.C.
   b. COUNTY: WILLIAMSBURG ??
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ???
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

77-3

99

3. **NAME OF DECEASED** (Type or print): First T. Middle J. Cooper Last COPPER/

4. **DATE OF DEATH**: Month AUG Day = 12 Year 19 67

5. SEX: male

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-28-19

9. AGE (In years last birthday): 47 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. **INFORMANT** Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): HEMOrrhage
DUE TO (b): Stab wounds of Arm and chest
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

981 X

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

3

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): stabbed in drunken brawl

20c. TIME OF INJURY Month, Day, Year Hour a.m. M p.m. 8-12-67 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): cannery shack

20f. (City or town) Trappe (County) Talbot (State) Md.

21. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Louis Welty M.D.
EXAMINER'S NAME (Type): Welty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
for DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 8-13-67

23a. BURIAL (CREMATION) REMOVAL (Specify)

23b. DATE THEREOF: 8-21-67

23c. NAME OF CEMETERY OR CREMATORY: U of Md. Med. Schl

23d. LOCATION (City or Town): Baltimore (County): Md. (State)

24. FUNERAL DIRECTOR ADDRESS

25a. REC'D BY REGISTRAR DATE AUG 23 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11542

Item #2 taken from birth certificate kk

11548

CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b: 14 hrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Memorial Hospital

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before odmission)
   a. STATE: Maryland
   b. COUNTY: Talbot
   c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Trappe
   d. STREET ADDRESS: RFD #1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Baby — Middle: Girl — Lost: Copper

4. **DATE OF DEATH**: Month: Aug — Doy: 18 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 18, 1967

9. AGE (In yeors lost birthday) yrs.

IF UNDER 1 YEAR: Months | Doys

IF UNDER 24 HRS.: Hours: 14 | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): TALBOT - Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Henry Thompson

14. MOTHER'S MAIDEN NAME: Myrtle Copper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.

17. **INFORMANT** Address: Myrtle Copper

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Anoxia
DUE TO (b): Congenital atelectasis
DUE TO (c): Prematurity
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this hospital) attended the deceased from Aug 18, 1967 to Aug 18, 1967, that (I) (we) last saw the deceased alive on Aug 18 1967, and that death occurred at 8:05 P.M., from causes and on the date stated above.

22a. SIGNATURE: Willie H. Hatfield M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/23/67

22c. PHYSICIAN'S NAME (Type): William H. Hatfield, M.D.

22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-21-67

23c. NAME OF CEMETERY OR CREMATORY: Trappe Station

23d. LOCATION (City or Town) (County) (State): Trappe Station, Md.

24. FUNERAL DIRECTOR: Barbara L. Dashiell — ADDRESS

25a. REC'D BY REGISTRAR DATE: AUG 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11543

CERTIFICATE OF DEATH

11549

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Talbot MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Md. b. COUNTY: Caroline
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON c. LENGTH OF STAY IN 1b: 11 HRS. 25 MIN.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Federalsburg, Md.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial	d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Walton	M	Coulbourne	8	12	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white		July 30, 1877	90 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired carpenter	same	Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Newton Coulbourne	Catherine Marine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	218-16-6719	Mrs. Merle Glessner Federalsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO: Arteriosclerotic heart disease — Hrs. Min. Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Long h/o congestive heart failure — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/11/67, 19 67, to 8/11, 19 67, that (I) (we) last saw the deceased alive on 8/11 19 67, and that death occurred at 4:15 PM, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Jacques R Caldwell		8/12/67
22c. PHYSICIAN'S NAME (Type): JACQUES R. CALDWELL, M.D.	22d. ADDRESS: Duke Anne's Lane, Easton, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
burial	Aug. 14, 1967	Hillcrest Cem.	Federalsburg, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
[illegible]	[illegible] Federalsburg, Md.	DATE AUG 16 1967	J Charles Judge

12 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11544 Item 2, Film G391 8/6/67 cac 11550

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 1 h. 20 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL Easton
d. STREET ADDRESS: Rt. 4 "THREE GABLES"
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First George — Middle G — Last Davies

4. DATE OF DEATH: Month 8 — Day 5 — Year 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT 7 1900

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: GOVT SERVICE

11. BIRTHPLACE (County & State, or foreign country): SHORES CONNECTICUT

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY DAVIES

14. MOTHER'S MAIDEN NAME: MARTHA HUGHES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes give war or dates of service): W.W. I

16. SOCIAL SECURITY NO.: 730-52-6719

17. INFORMANT — Address: MRS GEORGE G. DAVIES - RURAL EASTON

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cachexia - severe — INTERVAL BETWEEN ONSET AND DEATH: months
DUE TO (b): carcinomatosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1965, 19__ to 8-5-67, 19__, that (I) (we) last saw the deceased alive on 8-5 1967, and that death occurred at 4:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: John M Reese Jr

M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-5-67

22c. PHYSICIAN'S NAME (Type): John M Reese Jr

22d. ADDRESS: St Michaels Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: AUG 8, 1967

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL

23d. LOCATION (City or Town) (County) (State): ARLINGTON, ARL. VA.

24. FUNERAL DIRECTOR: [illegible] — ADDRESS: Easton, Md

25a. REC'D BY REGISTRAR DATE: AUG 8 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11545

CERTIFICATE OF DEATH

11551

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 13 HR 35 Min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: New York — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn
d. STREET ADDRESS: 5018-19th.Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nellie — Middle: — Last: DeAngelis
4. DATE OF DEATH: Month: Aug. — Day: 13 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-23-1886
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Brooklyn, N.Y.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick Hassler
14. MOTHER'S MAIDEN NAME: Anna Reiger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Edith V. O'Connor — Address: Brooklyn, N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): STOKES-ADAMS SYNDROME — INTERVAL BETWEEN ONSET AND DEATH: 36 hr.
DUE TO (b): Coronary atherosclerosis — (?)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. H201
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12 Aug, 1967, to 13 Aug, 1967, that (I) (we) last saw the deceased alive on 12 Aug 1967, and that death occurred at 12:50 AM, from causes and on the date stated above

22a. SIGNATURE: Thorston Harrison — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 13 Aug 67
22c. PHYSICIAN'S NAME (Type): THORSTON HARRISON
22d. ADDRESS: Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-17-67
23c. NAME OF CEMETERY OR CREMATORY: Holly Cross
23d. LOCATION (City or Town) (County) (State): Brooklyn, N.Y.

24. FUNERAL DIRECTOR — ADDRESS: J. E. Boulais Greensboro, Md.
25a. REC'D BY REGISTRAR — DATE: AUG 15 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11546 — 11552

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1. PLACE OF DEATH
   a. COUNTY: Talbot
   b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Easton
   c. LENGTH OF STAY IN 1b: 25 Hrs. 30 mins
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Memorial Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
   a. STATE: Maryland
   b. COUNTY: Caroline
   c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Greensboro
   d. STREET ADDRESS: None
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jeannette; Middle: ; Lost: Englehart

4. DATE OF DEATH: Month: August; Doy: 14; Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-8-1888

9. AGE (In yeors last birthdoy): 78 yrs.

IF UNDER 1 YEAR: Months; Doys. IF UNDER 24 HRS.: Hours; Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & Stote, or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Engel

14. MOTHER'S MAIDEN NAME: Lena Englehart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 215-48-3260

17. INFORMANT: Mrs. Madeline Clough Address: Greensboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Cerebral Hemorrhage
DUE TO
(b):
DUE TO
(c):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
331 X
INTERVAL BETWEEN ONSET AND DEATH: < 48 Hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this hospital) attended the deceased from ____, 19__ to ____, 19__, that (I) (we) last saw the deceased alive an ____ 19__, and that death occurred at 8 19 P.M., from causes and on the date stated above.

22o. SIGNATURE: Robert W. Trever — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/14/67

22c. PHYSICIAN'S NAME (Type): Robert W. Trever M. D.

22d. ADDRESS: Easton, Maryland 8/15/67

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-17-67

23c. NAME OF CEMETERY OR CREMATORY: Greensboro

23d. LOCATION (City or Town) (County) (State): Greensboro, Md.

24. FUNERAL DIRECTOR: John E. Boulins ADDRESS: Greensboro Md

25o. REC'D BY REGISTRAR DATE: AUG 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11547 11553

1. PLACE OF DEATH
a. COUNTY Talbot
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON
c. LENGTH OF STAY IN 1b 43 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) Memorial Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE Maryland b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
d. STREET ADDRESS 808 Arcadia Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First NORA Middle Thelma Lost Geib
4. DATE OF DEATH Month 8 Doy 5 Year 1967

5. SEX Female
6. COLOR OR RACE white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3/31/1899
9. AGE (In yeors last birthdoy) 68 yrs.
IF UNDER 1 YEAR Months Doys
IF UNDER 24 HRS. Hours Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & Stote, or foreign country) Eglon, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jesse Fike
14. MOTHER'S MAIDEN NAME Ona Feather

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO. 265-40-5708
17. INFORMANT Address Jacob H. Geib, Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH 10 min.
DUE TO
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.
(b) Myocardial Ischemia — 5 wks.
DUE TO
(c) Myocardial Infarction

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, farm, foctory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (this haspital) attended the deceased from ____, 19__, to ____, 19__, that (I) (we) last saw the deceased alive on ____ 19__, and that death accurred at 6:15 P.M., from causes and on the date stated above.

22a. SIGNATURE Robert M. McDonald M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 8/9/67
22c. PHYSICIAN'S NAME (Type) Robert M. McDonald M.D.
22d. ADDRESS Easton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 8/7/1967
23c. NAME OF CEMETERY OR CREMATORY Fairview
23d. LOCATION (City or Town) (County) (Stote) Cordova, Md.

24. FUNERAL DIRECTOR Maurice F. Veasey & Son ADDRESS Easton, Md.
25o. REC'D BY REGISTRAR DATE AUG 14 1967
25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the deoth certificate be executed within 24 hours after death. Page 4 moy be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove sheet on papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

Item 18 Film 392 9-20-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11548 11554

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): EASTON MEMORIAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD. b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON 20.1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CHARLES Middle RONALD Last GIBSON
4. DATE OF DEATH: Month 8 Day 15 Year 1967
5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-13-49
9. AGE (In years last birthday): 18 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD. 6
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: FRANKLIN EARL GIBSON
14. MOTHER'S MAIDEN NAME: JULIA DOBSON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: MRS. JULIA THORPE, EASTON, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 433.0
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Died suddenly after dental operation
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Louis J Mulloy M.D.
EXAMINER'S NAME (Type):
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 8-17-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8-19-67
23c. NAME OF CEMETERY OR CREMATORY: AICH #405
23d. LOCATION (City or Town) (County) (State): EASTON - TALBOT - MD
24. FUNERAL DIRECTOR ADDRESS: C. H. DASHIELL - EASTON, MD
25a. REC'D BY REGISTRAR DATE: AUG 31 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11549 Item #9 Film #G392 8730767 ph

CERTIFICATE OF DEATH

11555

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Talbot — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: TALBOT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON c. LENGTH OF STAY IN 1b: 9 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Box 72, Rt. 2, EASTON, Md. 20-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): MemoRial	d. STREET ADDRESS: LONGWOODS Community e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Doy	Year
EMMA	V.	GIBSON	Aug	26	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years (last birthday))	IF UNDER 1 YEAR: Months / Doys	IF UNDER 24 HRS.: Hours / Min.
F.	NEGRO		9-8-1890	76 77 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	TALBOT - MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
RICHARD BLAKE	MARY JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	UNKNOWN	MARIE LEWIS - 122 E. SECOND St NEW CASTLE, DEL.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized peritonitis — INTERVAL BETWEEN ONSET AND DEATH: Uncertain
DUE TO (b): Ruptured carcinoma cecum with
DUE TO (c): Hemorrhage
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.
1530

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)			
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐	20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last sow the deceosed olive on _____ 19___, ond thot deoth occurred at 6A M, from couses ond on the date stoted above.

22a. SIGNATURE		22b. DATE SIGNED
Robert W. Trever	M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	8-26-67
22c. PHYSICIAN'S NAME (Type): Robert W. Trevor	22d. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	8-29-67	RICHARDS CEMETERY	EASTON Talbot. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Barbara Dashiell	426 Dover St Easton, Md.	AUG 28 1967	Charles Judge

2 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11550 — 11556

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Talbot
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Unionville
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: Edith — Last: Hayman

4. DATE OF DEATH: Month: 8 — Day: 2 — Year: 1967

5. SEX: F

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 4, 1961

9. AGE (In years last birthday): 6 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles Webster HAYMAN

14. MOTHER'S MAIDEN NAME: Edith JENKINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Edith HAYMAN — Address: Box 208 B. Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Thrombotic cerebral hemorrhage due to — INTERVAL BETWEEN ONSET AND DEATH: sudden
   DUE TO (b): Hypertension
   DUE TO (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4672

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Thurston Harrison M.D.

EXAMINER'S NAME (Type): THURSTON HARRISON

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: 4 Aug 67

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 8/6/67

23c. NAME OF CEMETERY OR CREMATORY: Richardson

23d. LOCATION (City or Town) (County) (State): Easton Talbot Md.

24. FUNERAL DIRECTOR: George H. Penfield — ADDRESS: Easton Md

25a. REC'D BY REGISTRAR — DATE: AUG 8 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11551

11557

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
   c. LENGTH OF STAY IN 1b: DOA 10 05 pm
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Talbot
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   d. STREET ADDRESS: 412 Goldsboro St
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Napoleon — Middle: Bonaparte — Last: Headley

4. **DATE OF DEATH**: Month: 8 — Day: 18 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑

8. DATE OF BIRTH: 2-7-14

9. AGE (In years last birthday): 53 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): chauffeur

10b. KIND OF BUSINESS OR INDUSTRY: taxi

11. BIRTHPLACE (State or foreign country): VA.

12. CITIZEN OF WHAT COUNTRY? usa

13. FATHER'S NAME: NAPOLEON B. HEADLEY

14. MOTHER'S MAIDEN NAME: ANNIE HARRISON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 229-07-7313

17. INFORMANT: MRS. ROBERT E. JOHNSON — Address: WHEATON, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Fracture cervical spine
   DUE TO (b): Fell down stairs
   DUE TO (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   INTERVAL BETWEEN ONSET AND DEATH: immed.

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell down steep, L shaped stairway on head

20c. TIME OF INJURY Month, Day, Year: Hour o.m. p.m. 9:50P 8-18-67 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home

20f. (City or town): Easton — (County): Talbot — (State): Md

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Louis S. Welty, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ for

EXAMINER'S NAME (Type): louis s.welty

Address (Street, city, town, or county):

22. DATE SIGNED: 8-18-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8/23/1967

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

23d. LOCATION (City or Town): SUITLAND, MD (County): WASHINGTON, D.C. (State):

24. FUNERAL DIRECTOR: MAURICE E. NEWNAM & SON — ADDRESS: EASTON, MD

25a. REC'D BY REGISTRAR DATE: AUG 23 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11552 11559

CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b: DOA
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Talbot
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   d. STREET ADDRESS: 13 Prospect Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First Emma Louise — Middle ~~Louise~~ ~~Emma~~ — Last Johnson

4. **DATE OF DEATH**: Month 8 — Day 6 — Year 1967

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 5/7/1905

9. AGE (In years last birthday): 62 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Caroline Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Cheezum

14. MOTHER'S MAIDEN NAME: Anna Sigman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 218-16-8274

17. **INFORMANT** Address: Charles L. Johnson, Easton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Cardiac Arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: minutes
   DUE TO (b): Myocardial Infarction
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerotic Heart Disease
   4201

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Lung Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/6, 1967, to 8/6, 1967, that (I) (we) last saw the deceased ~~alive on~~ ARRIVED DOA 19___, and that death occurred at 3:20 p.m., from causes and on the date stated above.

22a. SIGNATURE: J R Caldwell M.D. — ATTENDING PHYS. ☒ — MED. EXAMINER ☐ — STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): J. R. Caldwell

22d. ADDRESS: c/o S.P. Carney, M.D. Dorchman & Lane Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/9/1967

23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Memorial Park

23d. LOCATION (City or Town) (County) (State): Easton, Md.

24. FUNERAL DIRECTOR: Maurice E. Newnam & Son — ADDRESS: Easton, Md.

25a. REC'D BY REGISTRAR DATE: AUG 8 1967

25b. REGISTRAR'S SIGNATURE: Elberta Judge

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11553

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11561

1. PLACE OF DEATH
a. COUNTY Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sherwood
c. LENGTH OF STAY IN 1b DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE D.C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington
d. STREET ADDRESS 3035 Mass Ave SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Douglas Middle: Talbott Last: Massey
4. DATE OF DEATH Month: 8 Day: 20 Year: 1967
5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 27, 1939
9. AGE (In years last birthday): 27 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Air Heating + Cond
11. BIRTHPLACE (State or foreign country): Richmond Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Massey
14. MOTHER'S MAIDEN NAME: Edith Yates

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 231-48-2702
17. INFORMANT: Mrs. Jean Massey, Address 3035 Mass Ave. S.E. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental drowning — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour ~~a.m.~~ p.m. Month, Day, Year: 8-20 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Ches. Bay
20f. (City or town) Sherwood (County) Tal (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Louis O Welty M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) WELTY
Address (Street, city, town, or county)
DATE SIGNED 8-21-67

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 23, 1967
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) Richmond (State) Virginia

23. FUNERAL DIRECTOR: Harrison E. Leonard
ADDRESS: St. Michaels Md
24a. REC'D BY REGISTRAR DATE: AUG 30 1967
24b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME
5M 1/63

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the deoth certificate be executed within 24 hours after deoth. Page 4 may be retained by the hospital or attending physicion.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremotion, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11554 — 11562

CERTIFICATE OF DEATH

M

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): East-ton
c. LENGTH OF STAY IN 1b:
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOZMAN
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

20-1

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Harvey	H.	McQuay	August	7	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	WHITE		AUG 7, 1897	70 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RET. FERRY BOAT EMPLOYEE		TALBOT Co., MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
CHARLES HENRY McQUAY	IDA L. McQuay

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
	217-16-4759A	MRS. H.H. McQUAY, BOZMAN, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cachexia - months
DUE TO (b): carcinomatosis
DUE TO (c): carcinoma colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
153P

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** thot (I) (this hospital) attended the deceased from 1964, 19__ to 8-2-, 1967, that (I) (we) last saw the deceased alive an 8-2 1967 ond that death occurred at 4:10 M, fram causes and an the date stated abave

22a. SIGNATURE: Harry M Reeser — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ M.D.

22b. DATE SIGNED: 8-7-67

22c. PHYSICIAN'S NAME (Type): Harry M Reeser

22d. ADDRESS: A Nichols md

1

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	AUG 10, 1967	BOZMAN CEMETERY	BOZMAN, MARYLAND

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James E Leonard, A. Nichols md.	AUG 10 1967	Charles Judge

3

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

8-20 Pen 11555

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11563

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Penna
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia
d. STREET ADDRESS: 1270 S. 24th ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75-3

78

3. NAME OF DECEASED (Type or print): First: Clarence Middle: Miller Last: Miller

4. DATE OF DEATH: Month: 8 Day: 31 Year: 1967

5. SEX: M

6. COLOR OR RACE: N

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-5-89

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housemaid

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Not Ascertainable

14. MOTHER'S MAIDEN NAME: Not Ascertainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 178-38-8908

17. INFORMANT: Address: Mrs. T. Henry - 1270 So. 24th St

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage
DUE TO (b): Hypertension
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
331X
INTERVAL BETWEEN ONSET AND DEATH: Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Leon Welty M.D.
EXAMINER'S NAME (Type): WELTY
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ for
Address (Street, city, town, or county)

22. DATE SIGNED: 8-31-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-8-67
23c. NAME OF CEMETERY OR CREMATORY: Eden Cemetery
23d. LOCATION (City or Town) (County) (State): Dela. Co. Pa.

24. FUNERAL DIRECTOR: George F. Carey — ADDRESS: 1232 S. 20th St. Phila.

25a. REC'D BY REGISTRAR DATE: SEP 8 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11556 11564

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
   a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b: 20 min.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Talbot
   c. CITY OR TOWN (If outside carporate limits, write RURAL and give neorest town): Easton
   d. STREET ADDRESS: 13 Sycamore Ave.,
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Edward — Lost: Mullikin, Sr.

4. DATE OF DEATH: Month: August — Doy: 13, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 30, 1910

9. AGE (In yeors last birthday): 56 yrs.
   IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward C. Mullikin

14. MOTHER'S MAIDEN NAME: Bertie V. Hinton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 212-16-1920

17. INFORMANT: Mrs. Edward Mullikin, Address: Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Louis O Welty M.D.
EXAMINER'S NAME (Type): WELTY

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 8-14-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/16/1967

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill

23d. LOCATION (City or Town) (County) (State): Easton, Md.

24. FUNERAL DIRECTOR ADDRESS: MAURICE E. NEWNAM & SON, Easton, Md.

25a. REC'D BY REGISTRAR DATE: AUG 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11557

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11565

1. **PLACE OF DEATH**
   a. COUNTY: TALBOT — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): EASTON
   c. LENGTH OF STAY IN 1b: 15 YEARS
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): CLIFTON

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: TALBOT
   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): EASTON,
   d. STREET ADDRESS: CLIFTON
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: CHARLES — Middle: WESLEY — Last: PRETTYMAN

4. **DATE OF DEATH**: Month: August — Day: 9 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: OCTOBER 29, 1913

9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PARTS MANAGER

10b. KIND OF BUSINESS OR INDUSTRY: NOBLE MOTOR REBUILDERS

11. BIRTHPLACE (State or foreign country): EASTON, MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: CHARLES W. PRETTYMAN

14. MOTHER'S MAIDEN NAME: EVA JAMES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 217-05-3713

17. **INFORMANT** — Address: ROBERT PRETTYMAN — EASTON, MD -

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instnt

DUE TO (b): ASCVD — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Leon O'Nelty M.D.

EXAMINER'S NAME (Type): NELTY Jr

Address (Street, city, town, or county):

DATE SIGNED: 8-10-67

22a. BURIAL, CREMATION, REMOVAL (Specify) — 22b. DATE THEREOF: AUGUST 11, 1967 — 22c. NAME OF CEMETERY OR CREMATORY: PARSONSBURG CEMETERY — 22d. LOCATION (City, town, or county) (State): PARSONSBURG MARYLAND

23. FUNERAL DIRECTOR: R. Ellis Cook — ADDRESS: EASTON, MARYLAND

24a. REC'D BY REGISTRAR DATE: AUG 11 1967 — 24b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11558

CERTIFICATE OF DEATH

11566

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Michaels
c. LENGTH OF STAY IN 1b: 12 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Bentley Hay

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): St. Michaels
d. STREET ADDRESS: Bentley Hay
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lotus — Middle K. — Lost Quillin
4. DATE OF DEATH: Month 8 — Doy 29 — Year 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/27/1903
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months ___ Doys ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & Stote, or foreign country): Wood Co. Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank E. Konetzka
14. MOTHER'S MAIDEN NAME: Pearl N. Peters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 216-46-4951
17. INFORMANT: Address: Jennings B. Quillin, St. Michaels, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): cachexia - severe
172 X
Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse lost.
DUE TO (b): adenocarcinoma both ovd.
DUE TO (c): Endometrial adenoca.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o): generalized metastases

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this haspital) attended the deceased from 1953, 19__ to 8-29, 1967 that (I) (we) last saw the deceased alive on 8-29 1967 and that death accurred at 1:50 P.M, from causes and on the date stated above.

22a. SIGNATURE: Mary M Reese M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-30-67
22c. PHYSICIAN'S NAME (Type): Mary M Reese M.D.
22d. ADDRESS: St Michaels Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/31/1967
23c. NAME OF CEMETERY OR CREMATORY: St. Paul's Episcopal Churchyard
23d. LOCATION (City or Town) (County) (State): Berlin, Md.

24. FUNERAL DIRECTOR: MAURICE E. NEWNAM & SON, Easton, Md.
ADDRESS
25a. REC'D BY REGISTRAR DATE: SEP 1 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11558 — 11567

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 211 PROSPECT AVENUE

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
d. STREET ADDRESS: 211 PROSPECT AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
OLIVER	JOSEPH	RICHARD	AUGUST	8	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W		June 22, 1887	80 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
AUDITOR	RETIRED	HOUMA, LOUISIANA	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
CLAY LEWIS RICHARD	EVA THERIOT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	261-10-6446	MRS. OLIVER J. RICHARD	EASTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** thot (I) (this hospital) attended the deceased from _____, 19____, to 8 Aug, 1967, thot (I) (we) last saw the deceased alive an _____ 19____, and that death occurred at _____ M, from couses and on the date stoted obave.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Thurston Harrison		10 Aug 67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
THORSTON HARRISON	EASTON, MARYLAND

23a. (BURIAL) CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
	AUGUST 10, 1967	SPRING HILL	EASTON TALBOT MARYLAND

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
R. ELLIS CLARK	EASTON, MARYLAND	AUG 14 1967	Charles Judge

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11560 — 11568

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 13 HR. 15 MIN.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Caroline
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Ridgely, Maryland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Day	Year
John	Robert	Sewell	Aug.	17	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Colored		4/15/1901	68 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor	Various	Queen Anne's Co.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Perry Sewell	Roxie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	213-14-7955	Mrs. Sadie Saunders Hope, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the lung — INTERVAL BETWEEN ONSET AND DEATH: Uncertain
DUE TO
163X
Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse lost.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive an _____ 19___, and that death occurred at 2A. M, from causes and on the date stated above.

22a. SIGNATURE: Robert W. Trever M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Robert W. Trever
22d. ADDRESS: Easton Memorial Hospital, Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	8/19/1967	Roseville, Cemetery	Near Price, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Bennett Adkins Charlestown, Md	AUG 22 1967	J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11561 — 11571

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural McDaniel
c. LENGTH OF STAY IN 1b: 45 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania — b. COUNTY: Allegheny
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Pittsburgh
d. STREET ADDRESS: 1336 Shady Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RAYMOND — Middle TEMPLETON — Last SMITH

4. DATE OF DEATH: Month August — Day 10, — Year 19 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 20, 1888

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): executive

10b. KIND OF BUSINESS OR INDUSTRY: research lab.

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania, Allegheny

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Robert S. Smith

14. MOTHER'S MAIDEN NAME: Anna Templeton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W. W. I

16. SOCIAL SECURITY NO.: 168-07-2500

17. INFORMANT: Templeton Smith — Address: 776 Valley View Rd. Pittsburgh, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO (b): Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: 2 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
1538

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from July, 19 67, to 10 Aug, 19 67, that (I) (~~we~~) last saw the deceased alive on 10 Aug 19 67, and that death occurred at 3:25 M, from causes and on the date stated above.

22a. SIGNATURE: R. Lane Wroth — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-10-67

22c. PHYSICIAN'S NAME (Type): Dr. R. Lane Wroth

22d. ADDRESS: St. Michaels, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 12, 1967

23c. NAME OF CEMETERY OR CREMATORY: Homewood Cemetery

23d. LOCATION (City or Town) (County) (State): Pittsburgh, Allegheny, Pa.

24. FUNERAL DIRECTOR: Maurice E. Neuenschwander — ADDRESS: EASTON, Md.

25a. REC'D BY REGISTRAR — DATE: AUG 11 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jagge

11562

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11573

1. PLACE OF DEATH — a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Easton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: ~~Residence before admission~~) — a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Easton Troth Fortune
d. STREET ADDRESS: 20.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First FREDERICK — Middle C. — Last THOMAS
4. DATE OF DEATH: Month August — Day 31 — Year 1967
5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 11, 1901
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): photographer
10b. KIND OF BUSINESS OR INDUSTRY: Self employed
11. BIRTHPLACE (State or foreign country): HEMPSTEAD, L.I.NY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FREDERICK C. THOMAS
14. MOTHER'S MAIDEN NAME: KATHERINE DOBBIN BROWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.War II 1944/46
16. SOCIAL SECURITY NO.: 094093640
17. INFORMANT: FREDERIC C. THOMAS JR. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Anemia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Bleeding from G.I. Tract — 3 months
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 578X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Osteomyelitis of 2 lumbar vertebrae
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 14 1967, to Aug. 31 1967, that (I) (we) last saw the deceased alive on Aug. 31 1967, and that death occurred at 10:45 M, from the causes and on the date stated above.

22a. SIGNATURE: Kurt Lederer — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Sept. 1, 1967
22c. PHYSICIAN'S NAME (Type): KURT LEDERER
22d. ADDRESS: QUEEN ANNE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: Sept. 1 '67
23c. NAME OF CEMETERY OR CREMATORY: GREENMOUNT
23d. LOCATION (City, town, or county) (State): Balto Md

24. FUNERAL DIRECTOR'S SIGNATURE: Wells Clark — ADDRESS: Easton Md
25a. REC'D BY REGISTRAR — DATE: SEP 5 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Kurt Letterer

Queen Anne, Md.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11563

CERTIFICATE OF DEATH

11574

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest tawn): St. Michaels
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address): Rio Vista Nursing Home St. Michaels, Md.

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn): Trappe (rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Courtenay Courtney — Last: Valliant

4. DATE OF DEATH: Month: 8 — Day: 5 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 18, 1884

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Wholesale Grocery

11. BIRTHPLACE (County & State, or foreign country): Talbot Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Valliant

14. MOTHER'S MAIDEN NAME: Ardilla Merrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 217-44-1895

17. INFORMANT: Mrs. Herbert White, Salisbury, Md.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cachexia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma of the bladder
DUE TO
(c): Uremia

INTERVAL BETWEEN ONSET AND DEATH: 1 yr +

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10 July, 19 67, to 8-5-, 1967, that (I) (we) last saw the deceased alive on 8-5-67 19, and that death occurred at 8:00 PM, from causes and on the date stated above.

22a. SIGNATURE: Guy M. Reeser Jr.
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-7-67

22c. PHYSICIAN'S NAME (Type): Guy M. Reeser, Jr. M.D.

22d. ADDRESS: St. Michaels, Maryland 21663

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/8/1967

23c. NAME OF CEMETERY OR CREMATORY: Merrick Cemetery

23d. LOCATION (City or Town) (County) (State): Trappe, Md.

24. FUNERAL DIRECTOR: MAURICE E. NEWNAM & SON
ADDRESS: Easton, Md.

25a. REC'D BY REGISTRAR DATE: AUG 10 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11564 — Items 8 & 9 Film G391 8/21/67 kk — 11575

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 7Hr. 5Min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Reisterstown 03-2
d. STREET ADDRESS: 17 Berrymans Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JANet VIRGINia — Middle: — Last: Vehstedt

4. DATE OF DEATH: Month: August — Day: 9 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 7/20/45

9. AGE (In years, last birthday): 22 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10b. KIND OF BUSINESS OR INDUSTRY: Sales Co

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U SA

13. FATHER'S NAME: Paul Dailey

14. MOTHER'S MAIDEN NAME: Helen Chapman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 212-50-5296

17. INFORMANT — Address: Husband Larry Vehstedt

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Severe head Injurys — INTERVAL BETWEEN ONSET AND DEATH: 8 hr
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): mostly Rt Side of Skull
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto Accident - Ran into Rear of Truck

20c. TIME OF INJURY Month, Day, Year: Hour 9:30 a.m. p.m. 8-8 19 0

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): US 50

20f. (City or town) Queenstown (County) (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: C R Layton M.D.
EXAMINER'S NAME (Type): C. R Layton
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Centreville, Md

22. DATE SIGNED: 8-5-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 12, 1967

23c. NAME OF CEMETERY OR CREMATORY: Evergreen Mem. Gardens

23d. LOCATION (City or Town) (County) (State): Finksburg, Carroll, Md.

24. FUNERAL DIRECTOR: H. J. Eckhardt — ADDRESS: Owings Mills, Md.

25a. REC'D BY REGISTRAR DATE: AUG 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11565

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11576

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND (MARYLAND)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Caroline
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Denton, Maryland
d. STREET ADDRESS: 312 5th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: THOMAS — Lost: WISE

4. DATE OF DEATH: Month: August — Doy: 13, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 10,1921

9. AGE (In yeors last birthday) yrs.: 46

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Nassowadix, Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Thomas Wise, Sr.,

14. MOTHER'S MAIDEN NAME: Not known by widow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): Not known

16. SOCIAL SECURITY NO.: 224-18-2498

17. INFORMANT: Ellen F.Wise(Widow) — Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intraabdomial Hemorrhage of t — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
(b): Traumatic rupture of the liver — minutes
DUE TO
(c): Bullet wound of the liver — Minutes

Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse last.

981X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): ~hot in the abdomen by an assailent

20c. TIME OF INJURY Month, Doy, Yeor: Hour o.m. p.m. 9 — 8/15/67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Labor camp

20f. (City or town) (County) (State): FD Denton Maryland

21. I **certify** that I took charge of the remains described above, held an Autapsy ☒, Inspection ☐, Inquiry ☒, and in my opinian death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: H. B. Plummer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): H.B. PLUMMER

Address (Street, city, town, or county): Preston, Maryland

22. DATE SIGNED: 8/16/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-18-1967
23c. NAME OF CEMETERY OR CREMATORY: St.Paul ME Church Cem.
23d. LOCATION (City or Town) (County) (State): Williston, Caroline MD.

24. FUNERAL DIRECTOR — ADDRESS: Charles W.Hill, Mortician, Denton, Md

25a. REC'D BY REGISTRAR DATE: AUG 18 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge